

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9880 163-042039
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9880

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 75 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 543 Rosedale	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year

MORRIS SIGAN Oct. 3, 1963

5. SEX Male 6. COLOR OR RACE Cauc. 7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ 8. DATE OF BIRTH 5-28-1880 9. AGE (last birthday) 83

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee 10b. KIND OF BUSINESS OR INDUSTRY Scrap metal 11. BIRTHPLACE (City and state or country) Russia 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Sonya Sigan 13b. MOTHER'S MAIDEN NAME Unk. 14. NAME OF HUSBAND OR WIFE Rebecca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Ida Bernstein 7305 Lindell

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Infected foot
DUE TO (c) 0.53.4
INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility, Generalized arteriosclerosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept. 13, 1957 to Oct. 3, 1963 and last saw her alive on Oct. 3, 1963
Death occurred at 11:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Stanley Bortman, M.D. 22b. ADDRESS 9311 Duane Drive 22c. DATE SIGNED 10/4/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. 23b. DATE 10/6/1963 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth 23d. LOCATION (City, town, or county) University City, Mo. (State)

24. FUNERAL DIRECTOR'S ADDRESS Berger Memorial 4715 W. Pherson. 25. DATE RECD. BY LOCAL REG. OCT 4 1963 26. REGISTRAR'S SIGNATURE Road Smith, M.D.

0880

8001

818

88

0881-88-2

STATEMENT BY LICENSED EMBALMER

0-143

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James J. Anderson*
Licensed Embalmer No. 4529

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.